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Learning from Supportive Housing Programs in New Jersey: Results from Interviews with Program Leaders

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Joel C. Cantor, Sc.D., Emmy Tiderington, Ph.D., M.S.W., and Oliver Lontok, M.D., M.P.H.

Introduction

There is substantial evidence that social factors influence health, health services use, and health care spending. Among these “social determinants of health”, housing is key (Doran, Misa, and Shah 2013). In a single night enumeration in January 2018, there were 9,303 homeless men, women and children in New Jersey, including nearly 1,300 individuals identified as “chronically homeless” (MHA 2018). Further, a 2019 New Jersey telephone poll showed that one-in-ten adults did not have a steady place to live or worried about losing it in the future, including about a quarter of low-income respondents.¹

Published research has shown that providing supportive housing to high-risk homeless populations leads to improvements in self-reported mental health, access to care, and overall wellbeing (Benston 2015; Kandilov et al. 2017; Kersten et al. 2014; Rog et al. 2014; Wright et al. 2016). Further, there is a substantial body of evidence that such supportive housing programs can lead to lower hospital emergency department (ED) and inpatient use as well as overall public system spending (Culhane, Metraux, and Hadley 2002; Kandilov et al. 2017; Kersten et al. 2014; Kyle and Dunn 2008; Ly and Latimer 2015; Martinez and Burt 2006; Rog et al. 2014).

Driven by these findings, there is growing interest among states in developing housing-related support services for Medicaid beneficiaries through state plan amendments and Section 1115 demonstration waivers. Federal guidance creates a path for states to create tenancy support benefits (e.g., assistance with housing applications, move support, landlord-tenant dispute resolution, and case management) for homeless Medicaid beneficiaries, although Medicaid cannot be used to pay for housing subsidies *per se* (CSH 2015; Wachino 2015).

Medicaid strategies to fund tenancy supports assume that such services would reduce Medicaid spending through reduced avoidable ED use, hospitalization, and placements in expensive institutional settings. The design of such benefits requires a deep understanding of populations in need of supportive housing and how such services can be optimally targeted to achieve more effective, and cost-effective, use of health services. Developing Medicaid housing support services also requires addressing key implementation challenges such as determining

¹ Unpublished data from the 2019 New Jersey Health and Well-Being Poll, Rutgers Center for State Health Policy.

what services should be covered, how to structure payments and monitor compliance, and how to best coordinate across the homeless services and health care sectors.

At the request of New Jersey policy agencies, the Rutgers Center for State Health Policy is conducting analyses to inform strategies for homeless population supports among New Jersey Medicaid beneficiaries. The project uses quantitative and qualitative methods. Drawing on six years of linked Medicaid and homeless services administrative data, statistical analyses are being conducted to: a) identify opportunities to generate savings and improve patient outcomes among Medicaid beneficiaries who use homeless services, and b) estimate the impact on Medicaid service use and spending of placement of homeless persons in permanent supportive housing. Results of those components of the project will be reported elsewhere. This report provides the results of a third project component using primarily qualitative research methods to complement the administrative data analyses. The analyses reported here have a dual purpose: a) to add context to, and support interpretation of, analyses of administrative data; and b) to identify lessons from existing supportive housing programs for the design of Medicaid-funded tenancy support services.²

Methods

This component of the project draws on semi-structured interviews with staff from diverse New Jersey based permanent supportive housing (PSH) programs. Using information from the NJ Homeless Management Information System,³ the PSH programs were selected to maximize programmatic and geographic diversity. In order to assure that we could glean lessons from well-established programs, only those serving comparatively large numbers of clients operating in for least three years from 2012-2015 were considered for selection. Contact information for program directors was obtained from Monarch Housing Associates, a collaborator on our study. We sent an email providing explanatory information about the study and requesting participation to five programs (see Appendix A for outreach materials). After extensive telephone follow-up, four of five programs contacted agreed to participate. Table 1 below describes the participating programs. The site that declined participation served primarily a HIV population in scattered site housing.

² The purposes of this component of the project has evolved based on findings based the quantitative analysis and priority information needs. Notably, it proved infeasible to conduct formal return-on-investment analysis for specific supportive housing programs.

³ Queries for selection of programs for interview was conducted using the full HMIS data, not linked to NJ Medicaid.

Table 1: Participating PSH Agencies

Project	PSH Placements 2012–15	Region	Program Features
A	113	South	Scattered site housing, works with several housing services providers
B	57	Central-West	Scattered site housing, several service providers
C	45	Central-East	Both scattered site and congregate housing, single service provider
D	49	North	Congregate housing, single service provider

Eight project staff were interviewed across the four organizations and between one and three individuals were interviewed per site. Three interviews were conducted individually and five subjects participated in group interviews. The executive director (or equivalent) was interviewed at each of the four participating organizations and one front line manager and/or other staff were also interviewed in all but one of the sites.

Data Collection Procedures

Data collection for this component of the study was conducted on a confidential basis to encourage program participation and candor on the part of interview subjects. Since one of our objectives was to determine the best way to collect information about the PSH programs, we collected data in several ways and were flexible in our information collection strategy. First, we asked leadership of each participating program to complete a questionnaire with descriptive information about their PSH programs (Appendix B). We requested information on: a) enrollment and turnover, b) pre-tenancy transition, tenancy sustaining, and post-tenancy transition supports, c) population eligibility categories, and d) current sources of funding for housing and support services. These categories and the specifics under each were adapted from federal Medicaid program guidance (Wachino 2015).

Next, we requested interviews with two staff from each program: the program’s director and one front-line homeless services supervisor or manager. While asked to conduct interviews with each staff member separately, we agreed to group interviews when preferred by the sites. We also allowed the project sites to add additional staff to group interviews if they requested to do so. We developed and used a semi-structured guide for all interviews (Appendix C). All interviews were conducted on-site at the housing services agency, were audio recorded and transcribed. Finally, we requested permission from the program directors to review program-related documents, such as approved grant applications, that were on file with our research partner, Monarch Housing Associates. All study materials and procedures were reviewed and approved by the Rutgers Institutional Review Board.

Analysis Procedures

We conducted simple descriptive tabulations of the completed questionnaires. Interview transcripts were reviewed to enumerate major emergent themes, and we conducted detailed thematic analysis (Boyatzis 1998). Specifically, in the first phase of analysis, data were coded using a deductive coding strategy in which the research questions were used to develop a starting list of possible codes and sub-codes (e.g., Financing: Adequacy/Dependability/Services Not Covered). During this phase, the analyst also reviewed the data for emergent inductive codes and further refined the coding scheme to develop a final codebook which was then applied to all transcripts. In the second phase of analysis, first-cycle codes were reviewed to identify patterns and to develop categories and themes. We selected direct quotes from the interviews to richly illustrate these themes. Finally, program documents were used to supplement the survey and interview analyses.

Findings

Survey Results

Three of the four sites returned completed questionnaires, although some questionnaire items were incomplete. The sites provided information on populations eligible for their programs and their service model. All served US Department of Housing and Urban Development (HUD)-designated chronically homeless individuals. This designation requires that clients have disabilities that impair their ability to live independently and have spent at least 12 months in an emergency shelter or place not fit for human habitation over a three year period. Some of the programs also service other categories of clients, such as veterans or those with HIV/AIDS.

All three programs responding to the survey reported paying for *housing* with funding from HUD and the NJ Department of Community Affairs (DCA), and two also reported collecting rent from clients. Two programs used HUD and DCA resources to fund support services and two reported relying in part or entirely on corporate or other charitable donations. All three programs serve a high proportion of clients with Medicaid, 86% on average (range 72%-99%).

Two programs served both individuals and family units, while the third served only individuals. One of the programs reported that it adhered to the Housing First model of PSH, a second site reported using a modified version of Housing First, and the third reported not using that model. According to the HUD, "Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry" (HUD Exchange, n.d.). Over time, HUD has increased the emphasis it places on using the Housing First model in its funding priorities.

Two sites provide program enrollment and turnover data (Table 2). These programs remained active serving significant numbers of clients. Site C grew substantially between 2016 and 2018. On average, about 22% (range 16%-37%) of clients left their housing placements across the three years in the two programs, although exiting clients were more than replaced with new placements across the programs and in most years.

Table 2: Program Enrollment and Turnover

Project	2016			2017			2018		
	Jan. 1	New	Exited	Jan. 1	New	Exited	Jan. 1	New	Exited
B*	80	23	22	82	27	30	79	23	13
C	139	91	22	205	87	42	241	61	39

*Household level data provided

The three sites responding to the survey reported offering a comprehensive range of pre-tenancy and tenancy sustaining services, and most reported that some or most/all of their clients needed such services (top two panels of Table 3). On average, the programs estimated that 20% (range 10%-39%) of clients “graduated” from their PSH placement each year, i.e., moved on independent, unsupported housing situation. Two reporting sites reported at least some need for supportive services to assist clients in moving on, yet none offered transitional support services for those clients (bottom panel of Table 3).

Table 3: Number of Programs Offering Specific Housing Supports and Program Ratings of the Share of Clients Needing Those Services*

	Number of Sites Reporting			
	Service Offered	Share of Clients Needing**		
		None/Few	Some	Most/All
Pre-Tenancy Transition Supports				
Tenant Screening and assessment	3			3
Individualized housing plan development	3			2
Housing search and application assistance	1	1	1	1
Identifying resources for move in (e.g., security deposit, move costs, furniture)	2			2
Arrange move in	3	1		2
Prevention, early intervention, crisis planning	3			3
Tenancy Sustaining Supports				
Early intervention in tenancy jeopardizing behaviors	3		1	2
Tenant rights & responsibilities training	3			3
Landlord relations coaching	3		2	1
Landlord dispute resolution	3		3	
Eviction prevention advocacy and linkage to community resource	2	1	2	
Housing recertification assistance	3		2	1
Housing support and crisis plan updating	3		2	1
Training in tenancy, lease compliance and household management	3		1	2
Post-Tenancy Transition Supports				
Early intervention in tenancy jeopardizing behaviors	0		1	1
Tenant rights & responsibilities training	0		1	1
Landlord relations coaching	0		2	
Landlord dispute resolution	0		2	
Eviction prevention advocacy and linkage to community resource	0		2	
Housing recertification assistance	0		2	
Housing support and crisis plan updating	0		2	
Training in tenancy, lease compliance and household management	0		1	1

*See Appendix B for exact question wording.

**Number of sites does not sum to 3 when items were left blank.

Interview Results

The following themes were identified in analysis of data collected across the four study sites.

Populations Served, Changing Needs

In the qualitative data, participants reported serving primarily special needs and homeless populations as defined by HUD, as well as HIV/AIDS, families and single populations. Eligibility for housing was generally **dictated by funding source** (e.g., HUD-funded individuals needed to meet HUD criteria for chronically homeless/disabling conditions) unless the funding used for the particular program did not specify requirements.

Notably, two of the study sites reported **changes in the needs of populations served** over time. One site reported a decreased need for HIV housing. “We have probably about 20 units or so that are designated for people with disabilities...and some of those come with vouchers. Those started out being folks who were strictly HIV, but as we've had such great success in managing HIV, there's not such the need.” (3-102). Another reported a significant uptick in recipients with substance use histories, particularly opioid use. “I'm seeing a high volume of people with opioid abuse history coming through. A lot of younger twenty somethings. For our family vouchers...I'm seeing a lot of your early twenties, single parent, that has a history of substance abuse with one or two children who are on methadone. That's kind of the trend I've been seeing for the last two years... It's quite staggering, the amount of people I'm seeing coming through.” (2-101)

Referral Process and Impact on Vacancies

Most of the study sites reported **using Coordinated Entry (CE) for referrals**. CE limited providers' discretion around referrals, as this participant explained, “We have no control over the referral process as far as picking and choosing who we can take. We have to interview whoever is the highest priority in that county.” (2-101) It also hindered their ability to seek out direct referrals from other entities such as hospitals and criminal justice system. However, participants did report that hospitals and health care providers were present at CE meetings.

The majority of providers reported **challenges with timeliness of referrals** which they attributed to the relatively new CE process. This delay in referrals then impacted the number of vacancies the agency had on a regular basis, as one provider said, “We have vacancies now, and we never did before when we were doing it ourselves, so there has been some growing pains with this new process... because we're not being referred appropriate clients in a timely fashion.” (1-101) Having regular vacancies was said to impact not only the agency but also the applicants.

“It helps if we could get people in a lot quicker because in the three to four months that it would take to get one person in, two people could move out...But coming in, to refill that room, takes too long. And it definitely hurts the applicant, but it hurts the [agency] as well. Like I said, there was a time when the process was different, when the applicants would come directly to us... Right now, we have

enough people that walk into this building every single day... every room would be filled and we'd have a waiting list. So, I mean, the fact that having the availability, having people coming in begging for these places and tell them, 'No. You have to wait.' And then you know, the room's wait empty. A lot of people are waiting." (5-104)

Scope and Intensity of Services

There was a general recognition by these providers that services should be **individualized to the person**. Most providers cited a once-a-month *minimum* frequency of contact, but they reported that actual **frequency of contact varies** significantly and depends on the needs of the individual. In response to the need to individualize care, a **range of services** are offered by these programs. For example, one agency offered "...budgeting classes, cooking classes, classes on how to qualify for a mortgage, how to go through Habitat for Humanity and get your own thing, or whatever...Sometimes it's Valentine's party or Thanksgiving baskets or dinner." (3-102) However, they said there are limitations to what the agencies can provide. In cases where a particular need cannot be filled, providers reported **collaborating and referring out** to other service providers, as this person said. "We'll provide as much support as possible. We also collaborate with other, let's say, mental health providers, or any other community resources that they're looking for, whether it be... if they need pantry information. We do a lot of collaboration because we can't do everything." (2-101)

Gaps in Funding and Support Services

Respondents reported that the **overall amount of funding for these programs is inadequate** and they described having to get creative by piecing together different funding streams to cover all related costs.

"The challenges are the lack of [funding]. There just needs to be more of, to be honest. The process that you go through for most of it is onerous, it's redundancy. ...We typically have to marry up some government funding with a little bit of private money because there are not too many government sources out there who are willing to be 100% of the funder. They want you to have cobbled together money from other sources, which is time consuming and cumbersome. It would be nice if some of them, 'Let's do 100%," because then it's just one application, one funder that you have to answer to, one set of rules that you got to follow, as opposed to where it could be two, three, four, five, depending on how many that you go to.'" (3-102)

Notably, some participants said that the already inadequate funding seemed to be shrinking at a time when the **populations being served have greater needs due to HUD's prioritization of the Housing First model**.

“We just have to get creative on how to keep it afloat. The part of the grant that allocates for service dollars seems to be diminishing. So, we have to get creative in other ways to fund that. And then, couple that with the Housing First population who needs more support. We're asked to do more, and we're getting less money.” (2-101)

Specific gaps in funding included **funds to cover transportation, security deposits and furniture, and supportive services**. Needed services included embedded medical providers familiar with the population served who could address physical and mental health, as well as substance abuse.

“We all would say many Hail Marys and, ‘Thank you, thank you,’ if we could get funding so we had somebody who was just dedicated to doing mental health counseling for our clients... All of that is part of holistically caring for that person. If we had someone that works with our people, they would be coming at it from a perspective of how to properly treat our clients...It would go a long way to minimizing the crisis.” (3-102)

“There are things I wanted to have in here, but based on the funding, we couldn't do... medical especially is a high priority...You know, diabetes, high blood pressure, all of the things that are basically killing these people that are in here...along with that, their addiction, because a lot of them have substance abuse problems.” (5-104)

Funding for financial counseling is also reportedly needed but lacking. Several participants said programs could benefit from funding for additional staff to cover these and other needs, or, as one provider pointed out, they could alternatively benefit from greater availability of outside providers familiar with their population that could offer these types of services instead.

“If I have 25 people that need really intensive budgeting counseling, that's a full-time job in its own, not to mention we have like another 75 families that are supposed to be receiving services from us. There are other places that do [budget counseling], but they do it primarily for the employees of an organization...not like for our population. ...For me, I feel like it's a void in the community.” (3-102)

Providers said that, for the most part, helping people move on from PSH to mainstream housing independent of services was not a focus of their work, as one person said “I was told that that was a philosophy of HUD. It was always permanent housing, and then they want to see the lengths of stay as long as possible, and so, no, I've never thought of that.” (101-1) There was one agency that had had some success in helping people move on using state-funded housing assistance and Section 8 Housing Choice Vouchers. Others reported that even though they wanted to assist people in moving on from services, this lack of funding for tenancy supports and

adequate staffing hindered their ability to do so. There was also reportedly a **lack of funding for post-tenancy supports**, as this person explained.

“They're on their own. Once they leave here, it's hard enough just you know, getting out the service. We don't get any credit for them once they're not here. We don't get any kind of match credit for that. And like I said...Along with the vouchers, you would need to have the staff that could deal one on one with the person. Right now, we give a limited amount of time to each person that we're dealing with. Some of them require a lot of hands on, but we can't afford to give you that much based on time. It takes a whole program in order to assist someone in getting from here to there. But us, you know, like I said, without the funding, we couldn't.” (5-104)

Discussion

In-depth qualitative interviews with eight experienced staff from four diverse, purposively selected New Jersey permanent supportive housing programs revealed a system actively managing services for very high need homeless populations. The agencies face a number of challenging circumstances, most notably: the rise of opioid use among homeless individuals and families; changing requirements of program funders, HUD in particular; and other changes such as systems for referrals to PSH. The study providers all voiced frustration with their ability to sustain adequate funding for housing supportive services to meet diverse needs of their clientele. One interview participant summed up the theme sounded by all, “We just have to get creative on how to keep it afloat.”

The structured survey returned by three of the four agencies revealed active, service rich programs offering a comprehensive range of pre-tenancy and tenancy support services. For the most part, in spite of experiencing fairly high turn-over rates, the programs did not offer structured services to help PSH residents move on to more independent housing, although some discussed ways they helped clients who were ready to move.

It is clear that the needs of PSH clients go well beyond housing alone, requiring that the PSH agencies address a broad range of social determinants of health and well-being for their highly vulnerable clients. The providers all painted a picture of service offerings were highly customized, depending on client needs. They struggled to meet diverse client needs directly, frequently making referrals to partner service agencies.

The use of the Coordinate Entry referral system by three of the four providers was seen as a barrier to program effectiveness. Some providers reported delays in placements leading to avoidable vacancies. Others voice frustration with their ability to establish direct referral pathways from local partner organizations, including hospitals. It is also clear that the rise of opioid misuse has created new challenges for the PSH agencies in the past couple of years.

Implications for Medicaid Support Services

It is clear that there is much to be gained from Medicaid funded tenancy support services. As noted, the study PSH programs all struggle to maintain stable funding for such services, while responding to growing needs of their clientele. Most of the clients of the interviewed agencies are Medicaid-covered (86% on average among the survey respondents). Since a Medicaid support services demonstration project would require the state to demonstrate federal budget neutrality, state officials may wish to target such services to homeless individuals with histories of preventable use of hospital inpatient and emergency department services. Current PSH referral mechanisms may be an impediment to targeting recruitment to healthcare high-users, for example, by establishing barriers to expedient direct referrals from hospitals.

Lessons for Research on PSH

The survey and qualitative interviews conducted yielded rich information that will complement the companion quantitative analyses that are part of the current research project. Linked HMIS-Medicaid data enable deep exploration of the characteristics and needs of homeless Medicaid beneficiaries and their response to PSH placement, but such data lack adequate description of variations in PSH program services. The survey and interviews revealed salient program variations, for example in the extent to which programs adhere to the principles of Housing First. Given the growth of substance use disorders among homeless populations, the extent to which PSH clients are accepted without regard to whether they are receiving drug treatment (a tenet of Housing First) could have significant implications for program effectiveness. Finally, although we planned individual interviews for this project, several sites requested group interviews. We found that the group conversations were efficient and did not impair our ability to collect the information we needed. In future studies, focus groups may further advance data collection goals and improve the efficiency of data collection.

The study survey yielded rich information, but may need to be augmented, for example by adding Housing First fidelity instruments, to be of maximum value for future evaluation studies. Interview subjects did not report difficulties completing the survey, although they mainly answered for the full range of PSH programs they offered, limiting the capacity to link survey responses to individuals in the HMIS-Medicaid data for analysis. Such linkages have potential to enrich “big data” work on PSH, but would require that responses be project-specific. Finally, while three of our four respondents successfully completed the survey, implementing an enhanced survey on a larger scale would likely require remuneration to offset the time required to complete the instrument.

Limitations

This study has some important limitations. First, only four PSH programs were included, thus findings cannot be broadly generalized. The project sites were selected purposefully and included

long-standing, comparatively high volume programs. This enabled us to delve deeply into their experiences, but again, may limit generalizability. Finally, we initially aspired to collect program cost data to enable calculation of return-on-investment to PSH program. In the end, we did not pursue this goal because no program served a high enough volume of residents to enable calculation of client-level savings and because of the burden that collection of cost data would have imposed on the programs. In spite of these limitations, the survey and qualitative interviews provided rich information that will strengthen the conclusions that can be drawn from the quantitative analysis components of this research project.

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Appendix A: Participant Outreach Letter

Continued on the following page.

Month XX, XXXX

Interviewee name
Organization
Street Address
City Name, State 00000-0000

Dear [name]:

We are writing to request an interview for a study of permanent supportive housing services available to persons covered by the New Jersey Medicaid program. We are contacting you because of your role in [NAME OF PROGRAM]. As you know, substantial evidence shows that social factors influence health status, health services use, and health care spending (e.g., from frequent emergency room and hospital admissions). Among these factors, housing is a significant social determinant. Driven by this evidence, we are exploring policy options for Medicaid-funded housing support services.

With funding from the New Jersey Medicaid program and The Nicholson Foundation, our study seeks to understand supportive housing program client recruitment, services delivered, and financing. Our overarching goal is to learn lessons that could inform the design of possible Medicaid funding of selected supportive services. In pursuing this objective, we would greatly value your expertise and insights.

Oliver Lontok, our study coordinator, will contact you to further explain the study. Ultimately we will ask you to complete a brief survey and participate in an interview of approximately 60 minutes. Your responses to our questions will be kept confidential, meaning that nothing you say will be identified as coming from you. Your name will not be associated or linked to any of your interview responses in our report or any other publication. With your permission, we will audiotape the interview to assure that we accurately capture your views.

If you have any questions about the study, please do not hesitate to contact Dr. Lontok at olontok@ifh.rutgers.edu or 848-932-5889 or me at jcantor@ifh.rutgers.edu, or 848-932-4653. We hope that you will be willing to participate in this important study.

Thank you for your consideration.

Sincerely,

Joel C. Cantor
Distinguished Professor and Director

If you have questions about your participant rights as a research subject, you may contact the Rutgers IRB Administrator at: Rutgers University Institutional Review Board for the Protection of Human Subjects, Liberty Plaza, Suite 3200 / 335 George St 3rd Floor, New Brunswick, NJ 08901, Phone: 732-235-9806, Email: humansubjects@ored.rutgers.edu.

Appendix B: Program Survey

Continue on the following page.

Medicaid and Permanent Supportive Housing (PSH) Study
Conducted by Rutgers Center for State Health Policy in collaboration with Monarch Housing Associates

Please answer each of the questions below to the best of your knowledge or correct information that we have provided. Questions may be addressed to Oliver Lontok (see page 4 of this form for his contact information).

1. Name of PSH program: _____

2. List all sites for this program.

Agency or Site Name	Address	Site supervisor name	Supervisor phone	Supervisor email

3. Number of PHS clients in place January 1, new placements during the year, and exiting during the year for each program site for 2016-2018.

Agency or Site Name	2016			2017			2018		
	# Jan 1	# New	# Exiting	# Jan 1	# New	# Exiting	# Jan 1	# New	# Exiting

4. About what percentage of your current PSH clients, across all project sites, are covered by Medicaid? ___ %.

5. To what extent does this program follow a *Housing First* model?

- Yes, this program is *Housing First*
- Yes, this follows the *Housing First* model, but with some modifications
- No, this is not a *Housing First* program

6. Pre-Tenancy Housing Transition Services Offered.

Service	Is this service offered as part of the program?	Whether offered or not, about how many clients in this program would benefit from this service?
Tenant screening and housing assessment	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Developing an individualized housing support plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Assisting with the housing search and application process	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Identifying resources to cover move-related expenses (e.g., security deposit, moving costs, furnishings, adaptive aids)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Arranging for and supporting the details of the move	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Ensuring that the living environment is safe and ready for move-in	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Developing a housing support prevention, early intervention, and crisis plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All

7. Housing and Tenancy Sustaining Services Offered.

Service	Is this service offered as part of the program?	Whether offered or not, about how many clients in this program would benefit from this service?
Early identification and intervention for behaviors that may jeopardize housing (e.g., late rent)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Education and training on the role, rights and responsibilities of the tenant and landlord	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Coaching on developing and maintaining relationships with landlords/property managers	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Assistance in resolving disputes with landlords and/or neighbors	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Assistance with the housing recertification process	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Coordinating with the tenant to review, update, and modify their housing support and crisis plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Continuing training in being a good tenant, lease compliance, and household management	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All

8. About what percentage of PSH clients in your program, across all project sites, "graduate from services" in a given year i.e., move on from the PSH program to housing that completely independent of your program's case management support?
 ___ ___ %

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9. Post-Tenancy Housing Transition Services Offered.

Service	Is this service offered as part of the program?	Whether offered or not, about how many clients in this program would benefit from this service?
Early identification and intervention for behaviors that may jeopardize housing (e.g., late rent)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Education and training on the role, rights and responsibilities of the tenant and landlord	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Coaching on developing and maintaining relationships with landlords/property managers	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Assistance in resolving disputes with landlords and/or neighbors	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Assistance with the housing recertification process	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Coordinating with the tenant to review, update, and modify their housing support and crisis plan	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Continuing training in being a good tenant, lease compliance, and household management	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All
Other, specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> None/Few <input type="checkbox"/> Some <input type="checkbox"/> Most/All

10. Does this program accept individuals, families, or both?

- Individuals
- Families
- Both

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11. Which of the following client groups are eligible for placement in this PSH program? (Check all that apply)

- HUD Chronically Homeless
- HIV/AIDS
- Severe Mental Illness
- Substance Use Disorders
- Other disability (specify: _____)
- Youth
- Adults
- Other, Specify: _____

12. What are the current source(s) of funding for housing rent costs in this program?

13. What are the current source(s) of funding for supportive services costs in this program?

THANK YOU

Please return this questionnaire to:
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Appendix C: Interview Guide

I. Respondent info

- a. What is your role at [Agency]? How long have you been in that role? ...at the agency overall? ...working in homeless services?
- b. What is your role in [PROJECT]?

II. Survey Review [FOR PROGRAM DIRECTOR ONLY]

- a. [Share copy of the completed survey], do you have questions about the survey? [Answer their questions.]
- b. Do you feel that the survey questions about services provided accurately capture what is actually delivered through the program? Probe: anything missing? Anything worded in a way that does not accurately capture what you deliver?
- c. Does the question about the populations eligible for the program accurately capture who can be enrolled? Probe: anything missing or not accurately capture eligibility criteria?
- d. Do the answers to other questions accurately capture the main features of your program and its funding? Probe: anything missing, inaccurate or incomplete?

III. Referral mechanism

- a. How are individuals currently referred to this program? Probe: Are any formal efforts made to get referrals or recruit “high utilizers” from service providers such as hospitals, healthcare organizations, or the criminal justice system?
- b. How hard has it been to fill the slots available in the project? Probe: [if not hard], do you think there is more need/demand for such placements in your service area than are available?
- c. Please describe the “typical” client in this program?

IV. Scope and intensity of services provided

- a. What are the contractual expectations, if any, for the frequency with which case management services must be delivered? Does this vary for different clients?

- b. On average, how much support do recipients of PSH in this program receive? Which support services are provided most often for: (i.) those receiving new placements, and (ii.) those already placed in housing?
- c. What supportive service needs does your program have difficulty meeting, if any?

V. Service Model

- a. How would you describe the service model used by the PSH providers at this agency? Probe: [If multiple sites] Are there any differences in service model across the service agencies in this program?
- b. Would the PSH programs at this agency be considered “Housing First” PSH?
- c. What changes, if any, has your agency made to the standard “Housing First” model? Why were these changes made?
- d. How much emphasis, if any, is placed on moving service users in the [PROJECT] to another physical setting after demonstrating clinical improvement or after a set period of time? Is there any emphasis on moving on from PSH in this program?

VI. Financing and reimbursement

- a. How is the funding for support services provided, for example, as annual grants or as fee-for-services payments for services rendered?
- b. [If not FFS] Does [your agency / the service providers supporting this program] have the capacity to bill for support services on a fee-for-service basis?
- c. Are there any support service related costs in your program that are not currently covered by state or federal resources? If yes, which services (Probe: transportation, non-face-to-face case management activities, other)?
- d. Year to year, how dependable are the funding source(s) for housing costs for the [PROJECT]?
- e. Year to year, how dependable are the funding source(s) for the project’s support services? Probe: what are the challenges to maintaining adequate funding? Are there particular kinds of services that are especially hard to find funding for?
- f. Do you feel that the funding for support services is adequate to: (i) meet client needs? and (ii) meet your contractual service obligations? If not, please describe the gaps.

VII. Other

- a. Is there anything else that you think would be important for us to know about your agency or the [PROJECT] PSH program?


The Rutgers logo is rendered in a red, serif font. The letter 'R' is significantly larger than the other letters and has a distinctive, sweeping tail that extends downwards and to the left.

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